

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05241

05237

1. PLACE OF DEATH

a. COUNTY

Worcester

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Berlin

c. LENGTH OF STAY IN lb

2 Yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Berlin Nursing Home

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

April 25, 1962

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

May 10, 1877

White

White

WIDOWED DIVORCED

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Mitchell Davis

14. MOTHER'S MAIDEN NAME

Roena Dennis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank, dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

217-36-1482D

Harry Cooper

Address

Frankford, Del. RED

INTERVAL BETWEEN
ONSET AND DEATH

5 yrs.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

443 X

Chronic myocarditis

Conditions, if any, which

give rise to immediate cause

(e), stating the underlying

cause last.

}

DUE TO

(b)

DUE TO

(c)

(d)

(e)

(f)

(g)

(h)

(i)

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05242

CERTIFICATE OF DEATH

05238

1. PLACE OF DEATH

a. COUNTY

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

MARYLAND

76 yrs

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)

a. STATE

b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

a. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF DECEASED
(Type or print)First
ViolaMiddle
m.Last
Griffin4. DATE
OF
DEATHMonth
AprilDay
15Year
1962

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9. AGE (in years
last birthday)

10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.

(Yes, no, unknown) (If yes give war or dates of service)

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

331 X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

19. INTERVAL BETWEEN
ONSET AND DEATH

24 hours

20. CAUSE OF DEATH

Cerebral Hemorrhage

Essential Hypertension

Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

19

p.m.

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 4-16, 1962 to 4-17, 1962, that (I) (we) last saw the deceased alive on 4-17, 1962, and that death occurred at 7 AM, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

David Rafat, M. D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

4-18-62

22b. DATE
SIGNED

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

DATE

25b. REGISTRAR'S SIGNATURE

24-51-1

1944-1945
1944-1945
1944-1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05243

CERTIFICATE OF DEATH

105239

1. PLACE OF DEATH

a. COUNTY

Worcester

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Snow Hill

c. LENGTH OF STAY IN lb

84 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

William Ernest

4. DATE OF
DEATH

Last

Month

Day

Year

5. SEX

COLOR OR RACE

Male, Colonial

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

July 13, 1877

9. AGE (in years
last birthday)

84 yrs

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY
(If any, name and address)

13. FATHER'S NAME

Alexander Martin

14. MOTHER'S MAIDEN NAME

Unknown

12. CITIZEN OF WHAT COUNTRY?

Snow Hill, Md

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

212-10-7648 Mrs. Mayla J. Gillett, Chester, Pa.

INTERVAL BETWEEN
ONSET AND DEATH

420.0 DUE TO

Conditions, if any, which
gave rise to immediate cause

(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Acute myocardial Infarction few hours

ASHD

unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING

OP. CONTRIBUTING

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

White

Not White

at work

at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from.....

4-6, 1962 to.....

4-6, 1962, that (I) (we) last

saw the deceased alive on.....

4-6, 1962, and that death occurred at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE

David Raft

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

4-9-62

22c. PHYSICIAN'S
NAME (Type)

DAVID RAFT

22d. ADDRESS

Snow Hill, Md

mc

23a. BURIAL, CREMATION, OR
REMOVAL (Specify)

23b. DATE THEREOF

April 9, 1962

23c. NAME OF CEMETERY OR CREMATORIUM

Elmwood Cemetery

23d. LOCATION (City, town or county)

Snow Hill

(State)

mc

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Clay E. Dennis, Snow Hill, Md

25a. REC'D BY REGISTRAR

APR 11 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Trahan

DATE

W

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05240

FOR STATE
HEALTH DEPT.

M

05244

TO DEPT: MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any part is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the M.D. director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm P.M.s. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Worcester				a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY Worcester	
Stockton		83 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Elmer		P		Parsons	April	17	1962	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours
Male	White	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	Oct. 28, 1878	83 5/19			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Carpenter	Local	Stockton, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Jehu Parsons	Mary E. Jones		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	None	Miss Maude E. Parsons, Stockton, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Minutes
976 X DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Mental depression		

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
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ACTUAL SIGNATURE <i>Robert C. La Mar</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	4-18-62	DATE SIGNED
EXAMINER'S NAME (Type)	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
Robert C. La Mar, M.D., 104 Bay St., Snow Hill, Md.	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 20/62	22c. NAME OF CEMETERY OR CREMATORIAL Portersville Cemetery	22d. LOCATION (City, town, or county) Stockton	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>James F. Dennis, Snow Hill, Md.</i>	ADDRESS	24e. REC'D BY REGISTRAR APR 20 '62	24f. REGISTRAR'S SIGNATURE <i>Lindsey L. Thomas</i>	

NEW YORK STATE DEPARTMENT OF MOTOR VEHICLES
NEW YORK STATE CERTIFICATE OF DEATH

12-664

STATE OF NEW YORK

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

TELE

DEATH CERTIFICATE

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05245

05241

1. PLACE OF DEATH

a. COUNTY

Worcester

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Snow Hill

c. LENGTH OF STAY IN 1b

88 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED

8. DATE OF BIRTH

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. PLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. MOTHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give war or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420.1
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

ACUTE CORONARY OCCLUSION

ARTERIO SCLEROSIS

INTERVAL BETWEEN
ONSET AND DEATH
MINUTES

15-YRS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

NON FATAL CORONARY OCCLUSION 1957

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from ... Jan 1962 to ... Apr 13, 1962, that (I) (we) last
saw the deceased alive on Apr 26, 1962 and that death occurred at 3:30 PM from the causes and on the date stated above.

22a. SIGNATURE

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
4/30/6222c. PHYSICIAN'S
NAME (Type)

Robert C. LAMAR

22d. ADDRESS

104 Bay St. Snow Hill, Md.

23a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)

23b. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

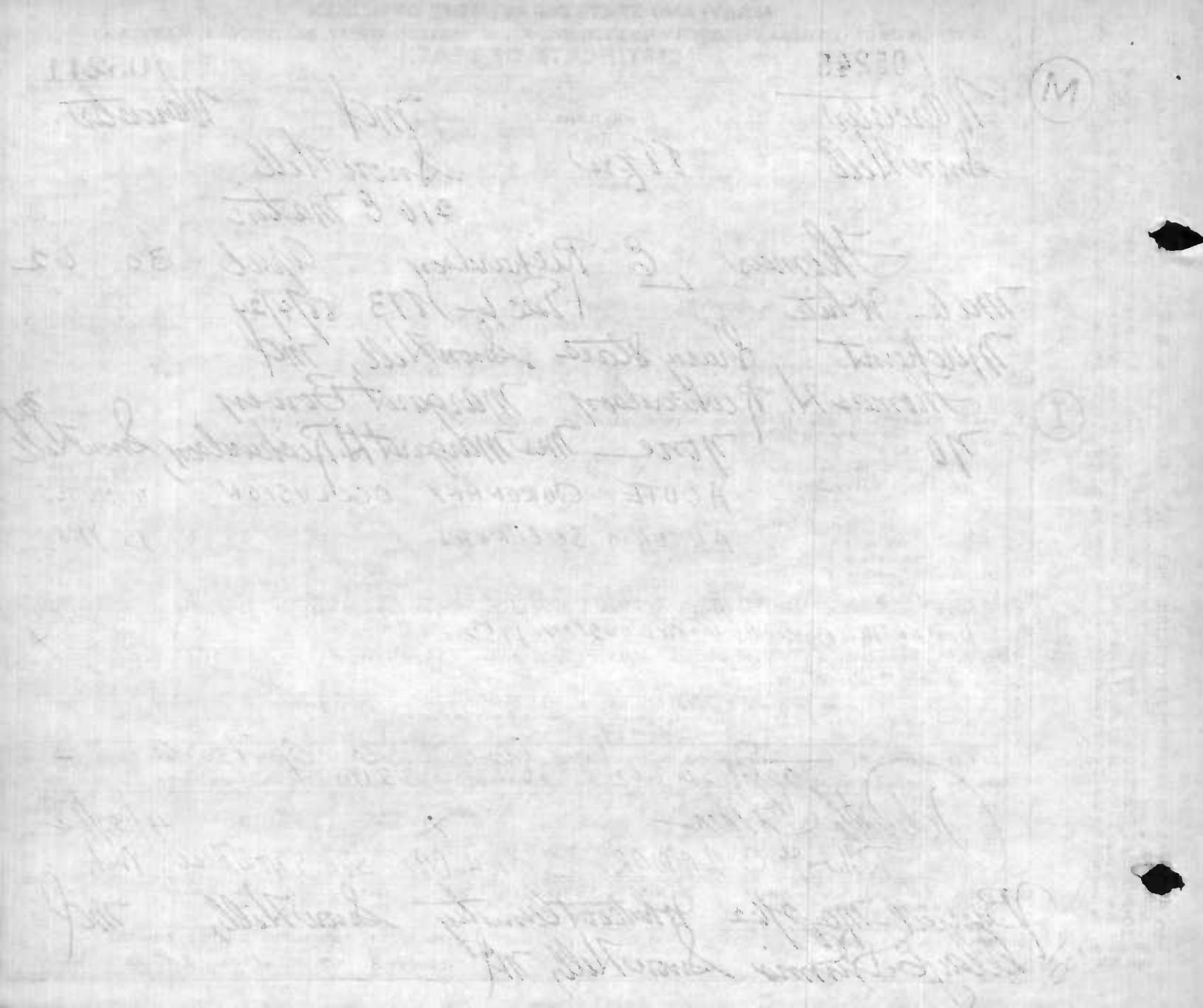
25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 9 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If age 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05246

CERTIFICATE OF DEATH

95242

1. PLACE OF DEATH
a. COUNTY

Worcester
Ovidlette

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

73 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

William Martin

Address

4. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED b. DATE OF BIRTH

WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work done, length of time working, etc., even if retired)

Retired Farmer own Farm

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James Riley

MARY

14. MOTHER'S MAIDEN NAME

Mary Stanford

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If deceased, write date of service)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Acute Myocardial Infarction

INTERVAL BETWEEN
ONSET AND DEATH

few hours

years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 While Not While
at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-8, 1962 to 4-8, 1962 that (I) (we) last saw the deceased alive on 4-8, 1962, and that death occurred at 3 P.M., from the causes and on the date stated above.

22a. SIGNATURE

David Rafat

M.D.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22b. DATE SIGNED

49-62

22c. PHYSICIAN'S NAME (Type)

DAVID RAFAT

22d. ADDRESS

Snow Hill

Md.

23. NAME OF CEMETERY OR CEMATORIAL LOCATION (City, town or county) (State)

Spring Hill Cemetery

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25. REC'D BY REGISTRAR

DATE FOR 11 '62

25b. REGISTRAR'S SIGNATURE

Clayton & Hanna

21500

19000

18000

17000

16000

15000

14000

13000

12000

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05247

CERTIFICATE OF DEATH

05243

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)		
WORCESTER	a. STATE MARYLAND b. COUNTY WORCESTER		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		
RURAL BERLIN	X RURAL BERLIN		
d. LENGTH OF STAY IN 1b	d. STREET ADDRESS		
71 yrs	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
MARGIE			Taylor	APRIL	29	1962	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	JUNE 25 1890	71 yrs.	Months	Days	Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		NEWARK, N.J.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
RICHARD HARMON	ANNA RICHARDSON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or grade of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	22101-4013	FARRELL TAYLOR	BERLIN MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1	distant
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) 420.1	5 years
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.	
PART III. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c) 420.1	5 years
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.	
Coronary occlusion acute	
Myocardial failure severe	
AS Cardiovascular disease	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED?
Diverticulitis acute	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour a.m. p.m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				
	19					

21. I certify that (I) (this hospital) attended the deceased from	1962 to April 29, 1962	that (I) (we) last saw the deceased alive on April 29, 1962, and that death occurred at 1:30 P.M. from the causes and on the date stated above.
---	------------------------	---

22a. SIGNATURE	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
FRANCIS J. TOWNSEND JR.					May 1, 62
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS				
FRANCIS J. TOWNSEND JR.	Ocean City, MD				

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City, town or county)	(State)
BURIAL	MAY 1, 1962	EVERGREEN	BERLIN	MARYLAND
24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Anna A. Burbage	Berlin, MD.	MAY 3 '62	Arthur & Anna	

1952

1952-06-25
Kurt H. Karpinski

1952-06-25
Kurt H. Karpinski

June 25, 1952

1952-06-25

Kurt H. Karpinski

1952-06-25

Kurt H. Karpinski

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05248

CERTIFICATE OF DEATH

05244

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop		c. LENGTH OF STAY IN 1b 32 Yrs		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BB				
3. NAME OF DECEASED (Type or print) Pewey		First Franklin	Middle Tingle	
4. DATE OF DEATH April 27, 1962 19		Month RFD	Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 24, 1898	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		9. AGE (In years last birthday) 63 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME George P. Tingle				
14. MOTHER'S MAIDEN NAME Anna M. Campbell				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) 16. SOCIAL SECURITY NO.				
17. INFORMANT Mrs. Gal Cropper Bishop, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocarditis. Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO Chronic myocarditis (c)				Address
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 4-26 1962
(County) BERLIN, MD.		(State) MARYLAND		
21. I certify that (I) (this hospital) attended the deceased from 4-26 1962 , that (I) (we) last saw the deceased alive on 4-26 1962 , and that death occurred at 2A.M. from the causes and on the date stated above				22b. DATE SIGNED
22e. SIGNATURE Clifford E. Schott		22f. ATTENDING PHYS. X	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Clifford E. Schott MD		22d. ADDRESS BERLIN, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/29/62	23c. NAME OF CEMETERY OR CREMATORIAL Old Fellows	23d. LOCATION (City, town or county) Bishopville, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Silveyville Del.		24b. ADDRESS ADDRESS	24c. REC'D BY REGISTRAR APR 30 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Thorne

1
FOR STATE
HEALTH DEPT.

TO DIRECTORY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05249

Item 1 Film G312 5/23/62

05245

1. PLACE OF DEATH

a. COUNTY

Worster

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Ocean City

c. LENGTH OF STAY IN 1b

DoA

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

on scene of death-

3. NAME OF
DECEDERED
(Type or print)

First

Middle

Last

Middle

4. DATE
OF
DEATH

APRIL

26

1962

Month

Day

Year

Year

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

9. AGE (in years
last birthday)
yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

218-10-1266

Mrs Myrtle Tubbs (Wife) R2 Berlin, MD

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4

DUE TO
(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(c)

Coronary Occlusion Acute

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

218-10-1266

Mrs Myrtle Tubbs (Wife) R2 Berlin, MD

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4

DUE TO
(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(c)

Coronary Occlusion Acute

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

218-10-1266

Mrs Myrtle Tubbs (Wife) R2 Berlin, MD

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4

DUE TO
(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(c)

Coronary Occlusion Acute

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

218-10-1266

Mrs Myrtle Tubbs (Wife) R2 Berlin, MD

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4

DUE TO
(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(c)

Coronary Occlusion Acute

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

218-10-1266

Mrs Myrtle Tubbs (Wife) R2 Berlin, MD

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4

DUE TO
(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(c)

Coronary Occlusion Acute

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

218-10-1266

Mrs Myrtle Tubbs (Wife) R2 Berlin, MD

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4

DUE TO
(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(c)

Coronary Occlusion Acute

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

218-10-1266

Mrs Myrtle Tubbs (Wife) R2 Berlin, MD

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4

DUE TO
(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(c)

Coronary Occlusion Acute

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

218-10-1266

Mrs Myrtle Tubbs (Wife) R2 Berlin, MD

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4

DUE TO
(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(c)

Coronary Occlusion Acute

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

218-10-1266

Mrs Myrtle Tubbs (Wife) R2 Berlin, MD

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4

DUE TO
(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(c)

Coronary Occlusion Acute

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

218-10-1266

Mrs Myrtle Tubbs (Wife) R2 Berlin, MD

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4

DUE TO
(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(c)

Coronary Occlusion Acute

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

218-10-1266

Mrs Myrtle Tubbs (Wife) R2 Berlin, MD

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4

DUE TO
(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(c)

Coronary Occlusion Acute

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

218-10-1266

Mrs Myrtle Tubbs (Wife) R2 Berlin, MD

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4

DUE TO
(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(c)

Coronary Occlusion Acute

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

218-10-1266

Mrs Myrtle Tubbs (Wife) R2 Berlin, MD

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4

DUE TO
(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(c)

Coronary Occlusion Acute

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

218-10-1266

Mrs Myrtle Tubbs (Wife) R2 Berlin, MD

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4

DUE TO
(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(c)

Coronary Occlusion Acute

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

218-10-1266

Mrs Myrtle Tubbs (Wife) R2 Berlin, MD

Address

WILHELMUS - ALEXANDER - DUCHESS OF YORK - 1712 - 1767
WILHELMUS - ALEXANDER - DUCHESS OF YORK - 1712 - 1767

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05252

CERTIFICATE OF DEATH

Reg. Dist. No. 05218

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bishop</i>		c. LENGTH OF STAY IN 1b 7		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bishopville</i>		d. STREET ADDRESS <i>Rural Box 273</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>Alice</i>	Middle <i>Wooden</i>	Last <i>Wooden</i>	4. DATE OF DEATH Month <i>Apr.</i>	Month <i>21</i>	Day <i>1962</i>	Year
--	-----------------------	-------------------------	-----------------------	--	--------------------	--------------------	------

5. SEX <i>Female</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 10, 1901</i>	9. AGE (In years lost birthday) <i>60 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. IF UNDER 24 HRS. Min. <i>0</i>
-------------------------	------------------------------------	---	---	---	---	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Portsmouth, Va.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
---	-----------------------------------	---	---

13. FATHER'S NAME <i>Rheuben Jackson</i>	14. MOTHER'S MAIDEN NAME <i>Julia Hunt</i>
---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Address <i>Augustus Wooden - Bishop, Md.</i>
---	-------------------------	--

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension C-V disease</i> (c)	INTERVAL BETWEEN ONSET AND DEATH <i>4 wks</i>
--	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Berlin</i>	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from <i>5/14</i> , 19 <i>57</i> , to <i>4/19</i> , 19 <i>62</i> , that I last saw the deceased alive on <i>4-19</i> , 19 <i>61</i> , and that death occurred at <i>7:00 A.M.</i> from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <i>Berlin Md.</i>	DATE SIGNED <i>7/24/62</i>
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ACTUAL SIGNATURE <i>Ivory U. Sully, Jr. M.D.</i>	PHYSICIAN'S NAME (Type) <i>Ivory U. Sully, Jr. M.D.</i>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/26/62</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Lincoln</i>	22d. LOCATION (City, town, or county) <i>Portsmouth Va.</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Watson</i>	ADDRESS <i>Pocomoke City, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>APR 26 '62</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Moore</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. To the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1252

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05250

CERTIFICATE OF DEATH

05246

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH

e. COUNTY

WORCESTER

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

RURAL NEWARK

c. LENGTH OF STAY IN lb

61 YRS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Dey

Year

5. SEX

m

6. COLOR OR RACE

W

7. MARRIED

 NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

APRIL 19, 1901

61 yrs.

9. AGE (in years last birthday)

IF UNDER 1 YEAR

Months

Dey

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FARMER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

WILLIAM WARREN

JENNIE GAULT

14. MOTHER'S MAIDEN NAME

IRONSHIRE, MD. U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

217-30-8038

NELDA LEE WARREN NEWARK

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

420
Conditions, if any, which
give rise to immediate cause
(e), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Coronary Occlusion
Operated cervical gland

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Dey, Year
Hour e.m. 20d. INJURY OCCURRED
While Not While
at work at work
p.m. 19 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-1-62 to 4-27, 1962, that (I) (we) last saw the deceased alive on 4-27, 1962, and that death occurred at 730 P.M. from the causes and on the date stated above.

22e. SIGNATURE Clifford E. Schott M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) Clifford E. Schott MD BERLIN, MD. 22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL 23d. LOCATION (City, town or county) (State)

BURIAL April 29, 1962 SUNSET MEMORIAL BERLIN, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25e. REC'D BY REGISTRAR

DATE

25b. REGISTRAR'S SIGNATURE

MAY 1 '62

Arthur S. Thorne

19. 08. 1994. Благодарю за помощь в решении
вопроса. Правда, я не могу
всё выразить в словах, но
всё же благодарю за помощь.
С уважением, А.С.П.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If age 4 or over, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08251

CERTIFICATE OF DEATH

05247

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Wardletree</i>		c. LENGTH OF STAY IN 1b <i>62 yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <i>Wardletree</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Carrie</i>		First <i>S.</i>	Last <i>Webb</i>
4. DATE OF DEATH <i>April 10 1962</i>	Month <i>April</i>	Day <i>10</i>	Year <i>1962</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 27-1888</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTH PLACE (County & State, or foreign country) <i>Salisbury, MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William & Dickerson</i>		14. MOTHER'S MAIDEN NAME <i>Anna Jane Jones</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mr Harold W. Webb, Wardletree, MD</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Breast</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 yr</i>	
DUE TO <i>Metastatic cancer to liver &</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Omen tum</i>			
DUE TO <i>Metastatic cancer to liver &</i>			
DUE TO <i>Omen tum</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1958</i> , 19....., to <i>April 10, 1962</i> that (I) (we) last saw the deceased alive on <i>April 9, 1962</i> and that death occurred at.....M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>Paul Coker</i>		ATTENDING PHYS. <input type="checkbox"/> M.D.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>Paul Coker</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, OR OTHER METHOD (Specify) <i>Burial April 13/62</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Spring Hill Cemetery</i>	
23d. LOCATION (City, town or county) <i>Wardletree, MD</i>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Clay & Burns Snow Hill, MD</i>		25a. REC'D BY REGISTRAR DATE APR 13 '62	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Turner</i>	

1900 - record of movements
1901 - wind blew in 2 directions
- wind

1901 Aug 22nd 8 AM
wind 1.0